Understanding Dual Diagnosis: Intellectual Disability and Mental Health

Course Code: REL-DD2013-DD-0

Description:
In the past it was thought that people with intellectual disabilities could not have mental illnesses. As a result, people with disabilities were not evaluated or treated for mental health conditions. Today we know that people with intellectual disabilities can and do suffer from mental illnesses, yet the needs of many people in this population are still not well served.

In this course, the term dual diagnosis refers specifically to people who have both an intellectual disability as well as a significant mental illness, such as depression, bipolar disorder, ADHD, or a personality disorder. People with a dual diagnosis face complex challenges and require a high level of support.

This course is based on sections of the book, Intellectual Disability and Mental Health: A Training Manual in Dual Diagnosis by Sharon McGilvery and Darlene Sweetland (NADD, 2011). The goal of this course is to raise awareness about the issues surrounding dual diagnosis, to present some typical and atypical signs of mental illnesses that may arise in this population, and to highlight how your interactions with individuals—whatever your role may be—can contribute to better supports for individuals.
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Section 1: Introduction

About This Course

In the past it was thought that people with intellectual disabilities could not have mental illnesses. As a result, people with disabilities were not evaluated or treated for mental health conditions. Today we know that people with intellectual disabilities can and do suffer from mental illnesses, yet the needs of many people in this population are still not well served.

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illnesses that may arise in this population, and to highlight how your interactions with individuals-whatever your role may be-can contribute to better supports for individuals.

**Page 2 Learning Objectives**

The goal of this course is to raise awareness about dual diagnosis among service providers and to teach learners how their interactions can help ensure that individuals with a dual diagnosis receive optimal services.

After viewing this course, you should be able to:

1. Explain what dual diagnosis is and why it is challenging for people to receive the right services.
2. Practice appropriate and effective communication strategies with a person who has limitations in receptive and effective language skills.
3. Name 3 mental illnesses, their characteristic symptoms, and some of the symptoms they might create in a person with intellectual disabilities.
4. Identify different types of information you might contribute to an individual’s assessment.

**Page 3 Note About Terminology**

This course is based on introductory chapters of the book, *Intellectual Disability and Mental Health: A Training Manual in Dual Diagnosis* by Sharon McGilvery and Darlene Sweetland, published in 2011. This book uses diagnostic terms and criteria from the *Diagnostic and Statistical Manual of Mental Disorders (4th ed., Text Revision)*, or the DSM-IV™. Since *Intellectual Disability and Mental Health* first appeared in 2011, however, the American Psychiatric Association has released a 5th edition of this work, the DSM-5™. The original terminology in McGilvery and Sweetland’s book has been updated in this course to be consistent with the DSM.

Note: *DSM™ and DSM-5™ are registered trademarks of the American Psychiatric Association. The American Psychiatric Association is not affiliated with nor endorses this course.*

**Section 2: Understanding Dual Diagnosis**

**Page 1 Meet Jim**
Section 2: Understanding Dual Diagnosis

Jim is a 46-year-old man who has been diagnosed with mild intellectual disability. Jim lived at home with his parents until he was 38 years old. Since his parents passed away, Jim has lived in a number of group homes. Jim has recently moved into another residential facility with three other people. Lately, Jim’s behavior has become increasingly aggressive and demanding.

Page 2  Meet Jim

Amer works as a support staff person at Jim’s residence. A number of incidents involving Jim have occurred over the past year and Amer is getting frustrated. A few times Jim has become angry with staff members. He has had incidents of defecating in his pants, although he is usually able to use the bathroom on his own. Jim is always very talkative with staff about his personal problems. Lately, he seems to need almost constant attention. He often follows Amer around during the day, repeating the same questions, sometimes very persistently. This becomes exhausting for Amer.

The other evening, Amer felt particularly worn out. Jim’s questions became so intense that Amer spoke to Jim sharply, ordering him to find something else to do. Jim’s emotions escalated and he seemed to be getting angry. Amer was able to defuse the situation, but he was disturbed by the incident and did not know what to do.

What is wrong here? What can Amer do?

Page 3  Meet Jim

Working with people with complex needs can be challenging. Day-to-day life can be so busy that there is little time or energy left over for behaviors that are particularly demanding or provocative. Sometimes, too, if a person starts acting withdrawn and stops participating, it can be tempting to let it go because it’s “easier” to deal with.

This course will explain why it’s important to discuss and explore changes in the behavior and mental states of the people you work. It will also teach you some basic behaviors and symptoms that can be a sign of an underlying psychiatric condition.

Page 4  Dual Diagnosis

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Section 2: Understanding Dual Diagnosis

In the past it was assumed that people with intellectual disabilities did not have mental illness. Any symptoms a person had were thought to be an offshoot of their disability or some type of learned behavior.

Today we know that people with intellectual disabilities can and do suffer from mental illnesses. Yet many people in this population remain undiagnosed or underserved. This course has been written to raise awareness and improve services for people with disabilities who also struggle with mental illness.

Page 5 What is Dual Diagnosis?

The term dual diagnosis is used when a person has more than one major disorder. In this course, dual diagnosis specifically refers to people who have a diagnosis of an intellectual disability together with a co-occurring mental illness such as depression, bipolar disorder, ADHD, or a personality disorder.

Page 6 Intellectual Disability

For a person to be diagnosed with an intellectual disability they must have three things:

1. An IQ score of less than 70-75.
2. Difficulty with adaptive behavior and cognitive tasks.
3. Symptoms of the disability must have been observed before the age of 18.

(Source: AAIDD)

Page 7 Mental Illness
Section 2: Understanding Dual Diagnosis

The National Alliance on Mental Illness defines mental illnesses as serious medical illnesses that affect and disrupt a person’s thinking, feeling, mood, and the way they relate to others. When untreated, they can interfere with a person’s ability to relate to other people and manage everyday life. Mental illnesses can affect anyone.

People who are diagnosed with both intellectual disabilities and mental illness face many complex challenges. They need a high level of support. To get the right services in place calls for a keen awareness of their challenges and an understanding of dual diagnosis itself.

What are some typical challenges that a person with a dual diagnosis might be facing?

Page 8  Stress and Daily Life

Stress adds to, and can even create, psychiatric disorders. Many people with a dual diagnosis have a complex life history that adds to their experience of stress. It is not unusual for people with intellectual disabilities to have lived in many different places. People who are middle-aged or older in particular may have been separated from their families and communities at a young age. Important relationships may have been disrupted or unstable. They may have experienced abuse, mistreatment, or neglect.

These can result in feelings of low self-esteem, defeat, and discouragement.

Page 9  Relationships

Living in many different residential settings also has an impact on the kinds of relationships that a person can have. Think about the most important people in your life. How many of them are paid to be in your life?

There is nothing wrong with having close relationships with staff members, but paid staff may change jobs or get burned out. A well-meaning staff member might do too much for the people they are supporting and expect too little. As a result, these individuals may not get the challenges they need to develop identity and self-confidence.

Page 10  Challenges to Diagnosis and Treatment

Studies show that people with intellectual disabilities face a higher than average risk of developing a
Section 2: Understanding Dual Diagnosis

mental illness. At the same time, they are more difficult to evaluate and treat. Why?

1. Psychiatric illness can be difficult to diagnose.

The most common methods used to determine the state of a person’s mental health are not as effective with people who have cognitive limitations or people with problems using expressive language.

2. There are systemic challenges.

Healthcare and support systems often fall short. There are not enough providers trained to work with this population. Even when a provider is available, it can be hard to get access to regular treatment: Individuals may resist treatment out of fear or suspicion. Changes in a person’s residence or frequent hospitalization can disrupt continuity of care. Budgetary changes may reduce or terminate services.

3. Mental health issues are overlooked.

Many people overlook the need for mental wellness in people with intellectual disabilities. Informed staff and professionals are needed to bridge the gap between mental health and disabilities’ service structures.

Page 11 What You Can Do

Think back to Amer and Jim. Instead of interpreting Jim’s behavior as manipulative or overly demanding, Amer can provide better support to Jim (and improve his own situation) if he starts by trying to understand the meaning behind Jim’s behavior.

When dealing with anyone, but especially people who have a dual diagnosis, it’s important to start with the assumption that “problem” behavior has meaning – then try to find out what is causing it.

Page 12 Steps Toward Understanding
Section 2: Understanding Dual Diagnosis

What might be causing Jim’s behavior? The best answer to this question will be found by examining all possibilities and coming up with a plan that takes the whole person into account. A step-by-step approach can be useful:

   Step 1. As a team, make a list of all the possible reasons for the person’s challenges. Make a list of all the medical and psychological resources you can use to rule in, rule out, or defer each possible reason.

   Step 2. Consider the person’s developmental level and goals and achievements appropriate to their developmental needs.

   Step 3. Consider the person’s emotional development and how the person’s experiences and history may impact the current situation.

   Step 4. Make sure your plans make accommodations to reduce the emphasis on using cognitive processes that are inherently difficult.

Your observations and first-hand knowledge of an individual you support can provide important information in this process.
Section 2: Understanding Dual Diagnosis

The term dual diagnosis is used when:

- A person has more than one major disorder
- A person has a condition that is a cross of two diagnoses
- A person has bipolar disorder
- A person has a psychiatric illness

This section explained that people with a dual diagnosis often have high levels of stress stemming from complex life histories. What is one reason for this?

- People with disabilities have very hard lives
- Many people with intellectual disabilities were removed from family and community at a young age
- Employment responsibilities for people with a dual diagnosis are often too great for them to manage
- Mental illness results in high levels of stress

When supporting anyone with “problem” behavior, but especially a person who has a dual diagnosis, it’s important to start with the assumption that:

- The person’s mental health problem is likely causing them to act out
- Their behavior is normal for people with multiple disabilities
- Their behavior is too complicated to understand
- Their behavior has meaning

Section 3: Basic Considerations

Page 1 Unique Experiences

Services for people with disabilities focus on overcoming inequalities and reducing the sense of “being different” from other people. At the same time, people with co-occurring intellectual disabilities and psychiatric disorders have unique experiences and challenges.
Section 3: Basic Considerations

Page 2 Factors Affecting Diagnoses

In the general population, if a person starts to struggle, they might seek out help all on their own. They might talk about what they are feeling and ask for an outside perspective. If they do not, the people around them may start to notice that something is wrong. Friends and family may intervene to get that person help. A healthcare or mental professional might be called in to diagnose the problem. Various treatments may be tried before finding something that works.

This same process may not take place for a person has an intellectual disability. A number of factors can complicate their situation.

Page 3 Challenges to Getting Help

If a person with intellectual disabilities struggles with depression, anxiety, or any other mental health issue, then it can be harder to figure out what is going on. Why?

Diagnostic overshadowing.
- If a person has more than one condition, attention to one diagnosis can block out other explanations. Symptoms caused by a mental health problem, for example, might be attributed to the intellectual disability.

Multiple medications (polypharmacy)
- Taking multiple medications can cause interactions and side effects. These sometimes mimic symptoms of a psychiatric disorder.

Atypical symptoms
- Some mental health disorders have different symptoms in people who also have an intellectual disability, so using standardized diagnostic criteria from the DSM-5 all by itself is problematic.

Communication deficits
- For people without strong language skills, self-reporting may not provide a good picture of what is going on. Practitioners must be able to gather and interpret observations from other people, paying attention to outward behaviors.

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Section 3: Basic Considerations

Untreated medical conditions

- Untreated medical conditions are more common with people who have a limited ability to describe or report symptoms, especially people with moderate to severe ID. These conditions may create symptoms that look like psychiatric symptoms.

All of these examples have something in common: People making assumptions and missing the real cause of the problem.

Page 4 Review of Barriers

Introduction: Match the challenge with the sentence that correctly describes it.

<table>
<thead>
<tr>
<th>Diagnostic overshadowing</th>
<th>This happens when symptoms caused by one disorder are wrongly attributed to the person having an intellectual disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking multiple medications.</td>
<td>In this situation, side effects that arise can mimic symptoms of a psychiatric disorder</td>
</tr>
<tr>
<td>Atypical symptoms in a person with ID</td>
<td>Because of these, the use of the usual diagnostic standards can be problematic.</td>
</tr>
<tr>
<td>Communication deficits</td>
<td>The person may not be able to report effectively on their thoughts, feelings, and symptoms.</td>
</tr>
<tr>
<td>Untreated medical conditions</td>
<td>When these are not identified, they can create symptoms that look like symptoms of psychiatric conditions</td>
</tr>
</tbody>
</table>

Page 5 Sorting it Out

One of the best ways to overcome these challenges is by learning more. The next few pages lay out some basic factors to consider when you are supporting mental wellness for people with intellectual disabilities.

Page 6 Developmental Stages
Section 3: Basic Considerations

People with intellectual disabilities move through developmental milestones like other people, just at a different pace. Because of the pace of their development, they are often treated as if they were much younger than their age. This robs them of the chance to meet new challenges and proceed to the next milestone.

Page 7 Emotional Experiences

When people do shift from one developmental stage to another, they often start to engage in problem behaviors. This is normal. It can be confusing and overwhelming to face new challenges and responsibilities, but it can also be a time of excitement and pride.

Adults who have mild to moderate levels of intellectual disabilities are likely to crave more independence, more decision-making opportunities, and more long-term relationships.

Page 8 Relationship Patterns

Relationship problems are the most common reason why people with a dual diagnosis are referred to behavioral specialists. Many people in this group have had very different patterns of relationships than the general population. Some people have experience prejudice and exclusion. They may feel deeply mistrustful of people. Other people might have a tendency to be overly familiar with people they don’t know.

Page 9

Finding out more about a person’s relationship history can give your insight into how a person relates to you and others. Consider the following questions:

- Did the person have the chance to form attachments with their parents?
- What is the person’s living arrangement and how frequently have they moved?
- What is the longest time this person has known someone?
- Is there a history of abuse?
- What is the person’s level of independence in the community?
- What is the person’s work history?
Section 3: Basic Considerations

Page 10 Communication Accommodations

How can you get answers to these kinds of questions?

By definition, a person with an intellectual disability has a disorder in their cognitive functioning. This can have an impact a person’s ability to communicate. For you, this might mean:

• It may be harder to make and follow through with recommended plans or treatment
• It may make it difficult for you to get to know them
• It may require you to work harder to interpret nonverbal messages

The next few pages will discuss how to adapt your interactions so that you get more from what someone communicates.

Page 11 Expressive Language

Expressive language refers to how we use spoken language. This is a skill that is often impacted in a person with intellectual disabilities, especially hard in emotional situations. A person with limited language skills will have difficulty describing the duration and severity of their symptoms. They will often use behaviors to communicate in addition to, or instead of, words. Behavior can be an effective way to communicate, but behavioral expressions take more effort to interpret.

Page 12 Expressive Language

If a person has limited expressive language:

• Engage in active listening.
• Summarize the message you heard from the person.
• Be patient and give the person time.
• Don’t answer for the person.
• Don’t ask “yes” or “no” questions.
• Don’t get caught up in all the details; focus instead on feeling.
• Be attentive to behavioral expressions.

Page 13 Receptive Language

Receptive language refers to how a person understands language “input.” This includes words but also
Section 3: Basic Considerations

gestures and abstract parts of speech—things like knowing when something is a question or how words are organized into topics and interactions. A person with poor receptive language can become overwhelmed by too much verbal input. This can be a problem because so many meetings and assessments are language based.

(Source: Gretchen Olsen, “Expressive vs. Receptive Language”)

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To support a person who has difficulty with receptive language:

- Discuss one piece of information at a time. Then have the person repeat what was said in their own words.
- Use only examples that are familiar to the person
- Use concrete language
  - Instead of saying “That was not appropriate”
  - Try “That made him want to move away from you”
- Use notes, pictures cues, and symbols when communicating information
- Encourage the person to keep a notebook with important information (with notes, drawings, etc.)

Page 15  Short-Term Memory

Short term memory is information that is only stored for a limited time. When you remember a phone number long enough to dial it and then forget it that is your short term memory at work!

Short-term memory is often affected when someone has an intellectual disability. People who have a dual diagnosis are often easily distracted and emotionally overwhelmed. These factors can make it difficult to remember instructions or information.

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To work effectively with limitations in short term memory:

- Assess a person’s emotional state before providing a lot of new information
- Provide instructions in writing or pictures
- Check in with the person a few minutes after communicating to see how much they remember

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Section 3: Basic Considerations

- Be patient when instructions need to be repeated
- Communicate in a quiet environment with minimal distractions

Page 17 Long-Term Retrieval

Long-term retrieval is the ability to find and retrieve learned information from long-term memory. When a person has difficulty finding this information, it’s best to:

- Avoid open-ended questions when possible. (How are you feeling? Why did you do that?)
- Follow-up open-ended question with some possible options.
- Use picture lists to provide choices. If they have a picture form, choices can be endless.
- Create a list of coping skills to use in an emotional situation. The person will not be dependent on long-term retrieval.

Page 18 Executive Functioning

Executive functioning is like the executive director of an organization: It is responsible for planning, organizing, concentrating, decision making, and multitasking. It’s easy to take this kind of function for granted, but we rely on it to carry out everyday tasks like planning and preparing dinner, getting to work (on time!), running errands during a break, or making and keeping to a budget.

Executive functioning is very difficult for a person with an intellectual disability. When you are creating behavior plans, teaching skills, or identifying supports, find coping strategies that decrease the need for executive functioning.

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To create supports or plans that reduce demand on executive functioning:

- Use written plans or create a calendar together as a team, including only the amount of information that the person can process at one time.
- Break tasks down into steps (accompanied by picture cues)
- Make a picture chart showing all the things a person finds calming
- Provide a structured schedule

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Section 3: Basic Considerations

Amer and Jim

The first section of the course discussed the importance of exploring all possible explanations for a person’s behavior.

Step 1. As a team, make a list of **all the possible reasons** for the person’s challenges.

Step 2. Consider the person’s **developmental level**

Step 3. Consider the person’s **emotional development**

Step 4. Make sure **accommodations** are made to reduce the emphasis on using cognitive processes

This lesson discussed emotional, developmental, and biographical factors that you might want to consider as part of this process.

If you were Amer, what different reasons for Jim’s challenges might you bring up at a team meeting?

- Changes in residence
- Grief over parents’ death
- Relationship history
- Need for more structured schedule

What other questions might be important to explore?

- Could Jim have any undiagnosed medical problems? Has he had a comprehensive physical?
- What are Jim’s relationships to the other residents of the apartment?
- What is Jim’s mental health and work history?
- Who is Jim closest to now?
- Has he had attachment or separation problems at work or at home?

Summary

This section presented some basic factors to consider when you are supporting someone who has a dual diagnosis. It described a number of issues that hinder accurate diagnosis and consistent treatment,

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Section 3: Basic Considerations

including diagnostic overshadowing, multiple medications, atypical symptoms of mental illness, communication deficits, and untreated medical conditions. All these difficulties show how important it is to consider every possibility when you are trying to get an accurate picture of a person’s situation. (Feel free to go back to review these before proceeding to the next section.)

Next, this section turned to some common emotional factors to consider. Many people in this group have a complex relationship history. Some of these involve abuse, neglect, and disrupted attachments. Whether these experiences are past or ongoing in the present, they can create stress in daily life and make it difficult to establish healthy ties to others.

Finally, this section discussed about some cognitive and communication deficits common among people with intellectual disabilities. Accommodating these challenges will not only help improve your communication skills relation, but they will help you provide and communicate concrete goals, information, and expectations that set the person up for success.
Section 4: Specific Psychiatric Diagnoses: Anxiety and Mood Disorders

Page 1 Back to Jim

What happens when the cause of someone’s behavior is misinterpreted? When staff interventions and plans aim at the wrong thing, it can cause a lot of frustration for everyone. Amer was irritated with Jim and his persistent questions because he interpreted Jim as:

- Attention seeking
- Manipulative
- Annoying and frustrating

What would happen if Amer tried to identify and address what Jim might be feeling and experiencing? He might explore whether Jim is feeling:

- Anxious
- Depressed
- Paranoid

Page 2 Presentation of Psychiatric Illness

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.) or the DSM-5 is typically used to identify psychiatric conditions. It lists symptoms and criteria for every mental health condition and is published by the American Psychiatric Association.

Page 3 Typical Versus Atypical Symptoms

Symptoms of mental health disorders can be different for people who have intellectual disabilities than for people in the general population. In some cases, they can look quite different from the criteria presented in the DSM-5. For this reason, using the DSM-5 alone to diagnose a person with an intellectual or developmental disability is problematic.
Section 4: Specific Psychiatric Diagnoses: Anxiety and Mood Disorders

This section provides an overview of psychiatric diagnoses related to depressive, bipolar, and anxiety disorders. You will learn about some of the standard signs of each one, as well as some the atypical symptoms that might arise in someone who has an intellectual disability.

Page 5

Depressive Disorders

Depression touches many lives in our society. The classic condition in this group of disorders is called Major Depressive Disorder. People with major depressive disorder feel a loss of pleasure or interest in all or almost all activity. They might also experience changes in weight, fatigue, difficulty concentrating, feelings of guilt or worthlessness, and a feeling of either agitation or lethargy.

Page 6

Atypical signs of depressive disorders

In individuals with an intellectual disability, depressive disorders may look different from the standard symptoms. A person might appear:

- More agitated or irritable than typically “depressed” or sad
- More prone to venting negative feelings outward rather than acting introspective or withdrawn
- More energetic, impatient, and rejecting of others
- More needy and attention-seeking

Depressive disorders are often overlooked, particularly among people in the profound or severe range of disability. This might be due to difficulty understanding what a person is communicating, or because, when a person becomes more passive, they can become “easier” to deal with.

Page 7

Review

Drag and drop the symptoms of depression listed below into the correct category.

Drop Zone 1: Typical Symptoms (DSM-5)
Correct Answers: Loss of pleasure, Difficulty concentrating, Feelings of worthlessness

Drop Zone 2: Atypical Symptoms with a Dual Diagnosis
Correct Answers: Agitated or irritable, Energetic and angry, Needy or attention-seeking
Section 4: Specific Psychiatric Diagnoses: Anxiety and Mood Disorders

Page 8  Bipolar and Related Disorders

In bipolar and related disorders, a person experiences abnormally elevated moods—called “manic” or “hypomanic” episodes. In a manic phase, the individual experiences a surge of intense, goal-directed energy and severely elevated, outgoing, or irritable moods. People who are manic are very changeable. Often, people with bipolar disorders also experience a major depressive episode, but this is not necessary for a diagnosis of a bipolar disorder.

Remember:
Cycles of challenging behavior are not necessarily signs of bipolar disorders. Cyclical behaviors can be caused by other conditions, including major depressive disorder or anxiety.

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Symptoms of bipolar disorders are similar for individuals with and without intellectual disabilities. These symptoms include:

- Insomnia or decreased sleep
- An extreme focus on pleasure-seeking activities (these are sometimes high risk, such as sexualized behaviors, or connecting with strangers online)
- Grandiosity
- Intense distractibility

Page 10  Atypical Signs of Bipolar Disorder

While symptoms of bipolar disorder are the same for people with and without intellectual disabilities, they may appear quite different in a person with an intellectual disability. What does this mean?

Page 11

Grandiosity is a common symptom of bipolar disorder. It’s often seen when people are very extravagant with money. People with intellectual disabilities may not have access to the level of resources needed to demonstrate typical forms of grandiosity.

A person with ID person may demonstrate grandiosity by:

- presenting themselves as a staff member
- making plans to change residences
- refusing medication
Section 4: Specific Psychiatric Diagnoses: Anxiety and Mood Disorders

- engaging unsuitable social interactions with peers or staff
- engaging in hypersexual behavior

**Note:** Since some developmental stages do not distinguish clearly between fantasy and reality, you should consider a person’s developmental level when deciding whether you think an individual’s claims are “delusional” or “grandiose.”

**Page 12** Rapid and Pressured Speech

People in manic states often use tense, rapid speech. They can be loud and difficult to interrupt. If a person does not use speech to communicate, however, this intensified use of language may express itself differently, such as in:

- Frequent yelling
- Uncontrollable laughing
- Repetitive questions
- Frequent interruptions

**Page 13** Elevated Mood or Irritability

For people with an intellectual disability, hyperactivity is often seen as a thread that unites all the associated symptoms of mania.

Other symptoms of elevated mood may appear as:

- laughing, giggling
- playfulness
- difficulty respecting personal boundaries
- increase in self-injurious behavior (irritability)
- signs of agitation like pacing
- aggression

**Page 14** Review
Section 4: Specific Psychiatric Diagnoses: Anxiety and Mood Disorders

Drag and drop the symptoms of bipolar disorders listed below into the correct category.

Drop Zone 1: Typical Symptoms (DSM-5)
Correct Answers: Insomnia, Focus on pleasure-seeking activity, Grandiosity
Drop Zone 2: Symptoms as expressed with a Dual Diagnosis
Correct Answers: Present self as staff member, Refusing medication, hyperactivity

Page 15  
**Anxiety Disorders**

There are many different kinds of anxiety disorders. What they have in common is the experience of extreme fear and worry.

The DSM-5 distinguishes between *fear*, which is an emotional response to real or perceived threats, and *anxiety*, which is the anticipation of a future threat.

Page 16  
Anxiety is often unreported among individuals with an intellectual disability. This is partly because these individuals are more likely to express themselves through behaviors instead of words. People frequently have multiple anxiety disorders. The following pages present an overview of some common anxiety disorders.

Page 17  
**Generalized Anxiety Disorder (GAD)**

People who have Generalized Anxiety Disorder (GAD) have a pervasive experience of excessive anxiety and worry for at least 6 months without any objective reason. This feeling is stronger and more all-consuming than normal stress and anxiety. People with GAD may also experience restlessness, irritability, muscle tension, fatigue, or insomnia. Treatment for GAD usually takes therapeutic approach that focus on how a person thinks. This helps people to “change channels” and “stop” thoughts that don’t make sense.

People who have intellectual disability, especially those with fewer language skills, are often not diagnosed. Instead they are viewed as “needy” or “attention-seeking.”

Page 18  
**Panic Disorder**
Section 4: Specific Psychiatric Diagnoses: Anxiety and Mood Disorders

A panic attack is a terrifying event. It is a sudden surge of fear that can overcome a person with the feeling that they are dying or “going crazy.” During a panic attack, an individual may have a pounding heart, shortness of breath, chest pain, dizziness, nausea, chills or hot flashes, or a sense that nothing they see is real. Panic attacks occur without an identified trigger. They are unpredictable.

A person with an intellectual disability who is having a panic attack may not be able to explain what they are feeling. Instead, you might notice signs on the outside like:

- Social avoidance
- Agitation, screaming, crying
- Reports of difficulty breathing
- Physical complaints
- Resistance to going outside or wanting to stay at home
- Increased dependency
- History of 911 calls
- History of wanting to go to the hospital

After someone has one panic attack, they are often terrified of having another. They may start to change their usual behaviors to avoid triggering other attacks. About 35% to 50% of individuals who have panic disorder also develop agoraphobia, a fear of being in places or situations where escape or assistance is impossible.

You should consider the possibility that a person has agoraphobia if their behavior changes and they no longer want to go outside. For example. This behavior can be misinterpreted as laziness, while it may be a sign that the individual is starting to avoid things and show agoraphobic tendencies.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder is marked by obsessive thinking and compulsive behaviors severe enough to become disabling.
Section 4: Specific Psychiatric Diagnoses: Anxiety and Mood Disorders

Compulsive behavior includes things like hand washing, excessive double-checking, or arranging things repeatedly. It often does not make sense and increases with anxiety, frustration or change. Research suggests that up to 3.5% of individuals with an intellectual disability may have OCD.

Page 22

Compulsive behaviors can be difficult to distinguish from motor tics, or tic-related symptoms like rubbing, tapping, staring, and other self-stimulatory behavior. One way to tell these two things apart is to see what happens when the behavior is stopped. A person with OCD is likely to become very agitated if they are unable to carry out the ritual.

Compulsive behaviors for individuals with an intellectual disability include particularly ordering, hoarding, telling, asking or rubbing. Examples might include:

- Dressing and undressing
- Open and closing doors, flicking lights on and off
- Hoarding objects
- Arranging furniture or other objects in the environment
- Emptying shampoo bottles and other toiletries
- Insistence on performing hygiene or other tasks excessively or in a strict order
- Grooming compulsions like skin picking or picking at another part of the body

Page 23

Review

Match the diagnosis with the symptoms it might cause in a person with intellectual or developmental disability:

<table>
<thead>
<tr>
<th>Generalized Anxiety Disorder</th>
<th>Needy, attention-seeking behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic Disorder</td>
<td>Resistance to going outside, history of 911 calls, reports of difficulty</td>
</tr>
</tbody>
</table>

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Section 4: Specific Psychiatric Diagnoses: Anxiety and Mood Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obsessive-Compulsive Disorder</td>
<td>Breathing, dressing and undressing, opening and closing doors, emptying shampoo bottles</td>
</tr>
</tbody>
</table>
Section 5: Specific Psychiatric Diagnoses: Psychoses and Other Disorders

Page 1  Meet Joannie

Joannie is a 42-year-old woman who recently moved into a new group home. She lived in her former home for five years, but recently had several incidents of hitting staff. The most recent incident caused an injury. As a result, the supervisor at this residence felt Joannie needed a higher level of care and gave her a 30-day notice.

Joannie has now been in her new home for two months. The first four weeks went well and she seemed to be settling in nicely. However, in the past month she has acted very agitated, hit two staff, and became strongly resistant to going in the bathroom. Joannie had always been somewhat reluctant to take a shower or use the toilet, but what began as resistance had evolved more and more into outright conflict. She begins to scream when it is suggested that she go on an outing and has not begun a day or work program yet. The honeymoon period at Joannie’s new residence seems to be over.

Page 2  Next Steps:

What would be a good first step for the staff at Joannie’s new residence?

1. Search for new residential situation for Joannie that can offer her more support than they are able to provide. **Sorry, that is not correct. There is not enough information yet to know what kind of support would work best for Joannie.**

2. Get Joannie to attend a day program. If she would only get out more, things would probably straighten out for her. **Sorry, that is not correct. There is not enough information yet to make this assumption.**

3. Send her back to her previous residence. She does not need more changes in her life. **Sorry, that is not correct. There is not enough information yet to know to conclude that this is best for Joannie.**

4. Call a team meeting to discuss staff experiences so far in getting to know Joannie and review her case history. **Correct!**

Page 3  Trauma and Stressor-Related Disorders

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Section 5: Specific Psychiatric Diagnoses: Psychoses and Other Disorders

Posttraumatic Stress Disorder (PTSD)

Posttraumatic stress disorder, or PTSD, is one of the most prevalent disorders among individuals with a dual diagnosis. It is estimated that 60% of people with an intellectual disability have experienced some type of trauma or abuse (Sobsey, 1994). Other studies suggest the rates are even higher.

A traumatic event involves actual or threatened death or serious injury. If you know that a person has lived through an event that caused them to experience intense fear, helplessness, or horror in response, you should consider posttraumatic stress disorder.

With PTSD, the traumatic event is persistently re-experienced through intrusive thoughts. Things in the present that resemble the event or have a symbolic connection to it can trigger traumatic memories.

A person with PTSD often experiences symptoms of increased arousal. These include:

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle reflex

Adjustment Disorders

A person with an adjustment disorder develops symptoms in response to a specific stressor. Their response seems out of proportion to the event and much more than what you might expect from normal bereavement. Adjustment disorders are associated with a higher risk of suicide and suicide attempts.

Adjustment disorders are common, especially among individuals with mild and moderate intellectual disabilities. They can appear if individuals have experienced numerous environmental changes during their lives.

A stressor might be:
Section 5: Specific Psychiatric Diagnoses: Psychoses and Other Disorders

- Move to a new home
- Loss of a caregiver
- Changes in comfort level
- Onset of illness

Events that trigger symptoms of an adjustment disorder may not seem that significant to other people. Often they are things that require a person to be more autonomous.

Page 7

Adjustment disorder should be considered when people exhibit symptoms of:

- Clinging
- Apparent loss of skills
- Withdrawal
- Irritability
- Aggression
- Self-injurious behavior
- Destructiveness
- Loss of earlier compliance

(See also Levitas and Hurley, 2007, *DM-ID*)

Page 8

Review

Let’s return to Joannie’s situation at her new residence. Joannie’s support team gets together to discuss their experiences so far and review her case history. They notice that there is not much information about Joannie’s background in the files that came to them from her previous residence. They decide to contact the people at her prior residence to see if they can find out more. They learn that Joannie had a history of sexual abuse from staff at another home that occurred while supporting her in performing ADLs.

Which of the following diagnoses do you think should be considered for Joannie?

**PTSD** (feedback: Joannie’s past history of abuse surround support with ADLs and her current resistance and outbursts of anger while toileting and bathing might indicate possible PTSD.)

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Section 5: Specific Psychiatric Diagnoses: Psychoses and Other Disorders

**Bipolar disorder** (feedback: Although Joannie seems more irritable, she does not seem to be showing signs of elevated energy, mood or hyperactivity associated with mania.)

**Panic disorder** (feedback: Joannie’s intense resistance to participating in outings and going to a day program might suggest a level of anxiety or fear typical of agoraphobia or panic disorder.)

**Adjustment disorder** (feedback: Recent changes in staff and yet another residential transition should be noted as stressors. These events, together with loss of earlier compliance, irritability, aggression, and apparent loss of skills might be signs of an adjustment disorder.)

**Page 9** Schizophrenia Spectrum and Psychotic Disorders

The term “psychosis” refers to a state where a person loses touch with reality. There are a number of different psychotic disorders, so careful evaluation is needed for an accurate diagnosis.

Even when a person has been diagnosed and is on medication, it takes a lot of cognitive thought and energy to remember that voices and delusions are not real.

**Page 10** Schizophrenia and Schizophrenia Spectrum Disorders

Schizophrenia and schizophrenia spectrum disorders are names given to disorders that a range of different symptoms. Negative symptoms might include the lack of social contact, interaction, physical movement, motivation, or emotional expression. They can also create “positive” symptoms like having delusions and hallucinations.

There are a number of psychotic disorders listed in the DSM-5. Some may have a less severe impact. A person with delusional disorder, for example, can have delusional beliefs that last for a month longer. Yet their everyday life is not significantly impaired. Delusional disorder is broken down into different subtypes, such as romantic delusions, jealous, or grandiose delusions.

**Page 11** Psychotic Disorders and Communication

Even individuals who have strong language skills can find it difficult to express their inner thoughts and feelings verbally. For people who cannot describe their delusional beliefs at all, psychotic disorders are...
Section 5: Specific Psychiatric Diagnoses: Psychoses and Other Disorders

very hard to diagnose, since delusions are one of the major criteria for a diagnosis of psychosis.

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Some behaviors that are not unusual for persons with moderate to severe intellectual disability may look similar schizophrenia spectrum disorders. For example, some behaviors common to people who have autism spectrum disorder.

Page 14  Unique Signs of Psychotic Disorders

Psychotic disorders are often accompanied by agitation, fearfulness, anxiousness, and confusion. For someone who is dually diagnosed, the following signs may be apparent:

- The person may seem very distracted or slow to react.
- The person may show emotions out of step with the situation
- Self-talking. (This should be distinguished from self-talk that is instructional or soothing.)
- Staring, or alternatively, covering eyes and ears
- Shadow boxing or strange postures
- Suspiciousness around food
- Decline in self-help skills
- Wearing multiple layers of clothing

Page 15  Always Rule out Medical Causes!

Medical conditions can mimic the symptoms of psychosis. People without strong verbal abilities may not be able to communicate their physical or emotional experience in detail. As a result, metabolic disorders, substance use disorders, neurological damage, infections, or nutritional deficiencies can cause symptoms that resemble those of psychosis. Certain sensory deficits, too, may cause behaviors that resemble the unusual behaviors seen in psychosis.

Page 16  Personality Disorders

Personality refers to a whole set of changing characteristics that influences how any one person thinks, what they enjoy, what they want to do, and how they act.

A personality disorder characterized by a persistent, long-term set of experiences, thinking, and behavior that is significantly different what is normally expected and accepted by the individual’s culture.

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The DSM-5 identifies 10 personality disorders, organized into 3 clusters. It is not unusual for people to show symptoms of several personality disorders from these different clusters. The following chart illustrates these clusters. Click on the individual names to read more about each disorder if you are interested in getting more information.

<table>
<thead>
<tr>
<th>Cluster A: “Odd or Eccentric”</th>
<th>Cluster B: “Dramatic or Emotional”</th>
<th>Cluster C: “Anxious or Fearful”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid personality disorder</td>
<td>Antisocial personality disorder</td>
<td>Avoidant Personality Disorder</td>
</tr>
<tr>
<td>Schizoid personality disorder (SPD)</td>
<td>Borderline personality disorder</td>
<td>Dependent Personality Disorder</td>
</tr>
<tr>
<td>Schizotypal personality disorder</td>
<td>Histrionic Personality Disorder</td>
<td>Obsessive-Compulsive Personality Disorder</td>
</tr>
<tr>
<td></td>
<td>Narcissistic Personality Disorder</td>
<td></td>
</tr>
</tbody>
</table>

Debates About a Personality Disorder Diagnosis

Diagnosing personality disorder in individuals with an intellectual disability has been somewhat controversial. Some clinicians don’t believe that personality disorder diagnoses should be given to individuals functioning below the mild level of intellectual disability (Dana, 1993). One reason for this is that the personality diagnoses are measuring the degree to which a person deviates from the “expectations of the individual’s culture.” This kind of measurement on the basis of “normal” is problematic.

Other Diagnoses

Let’s look briefly at a few other common psychiatric diagnoses:

- Impulse control disorders
Section 5: Specific Psychiatric Diagnoses: Psychoses and Other Disorders

- Attention deficit disorders
- Sleep disorders
- Dementia

Page 22 Impulse Control Disorders

People with impulse control disorders find it extremely difficult to exert self-control. These disorders are named according to the type of behavior that people are likely to engage in. Some examples are:

- Kleptomania (impulse to steal items), pyromania (impulse to start fires), and pathological gambling are easy to classify because they are associated by distinct behaviors.

- Intermittent explosive disorder: this is when a person is unable to resist aggressive impulses that result in assaultive acts. Be sure to explore underlying medical conditions that might be causing these aggressive behaviors!

Page 24 Attention Deficit/Hyperactivity Disorder (ADHD)

Attention Deficit/Hyperactivity Disorder, or ADHD, is a pattern of inattention or hyperactivity or both. The DSM-5 describes inattentive behavior as someone who:

- Does not pay attention to details
- Does not seem to listen
- Does not follow through on instruction or finish a task
- Has difficulty organizing
- Avoids or dislikes things that required sustained mental effort
- Is easily distracted
- Is often forgetful in daily activities

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Section 5: Specific Psychiatric Diagnoses: Psychoses and Other Disorders

The DSM-5 describes “hyperactive” as a person who:

- Fidgets with hands or feet and squirms in a seat
- Leaves seat in situation where remaining seated is important
- Runs about or climbs excessively; or (in adults) feels very restless
- Often talks excessively

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Some symptoms, like having a short attention span, are common to both ADHD and intellectual disability. This makes it difficult to diagnose ADHD. However, if a person has a dual diagnosis of an intellectual disability and ADHD, it’s very important to address ADHD-specific issues like organization, planning, decision making, and independent living. If ADHD is not identified and addressed, it can be very frustrating to people who would otherwise be capable of performing these tasks independently.

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Sleep Disorders

The presence of sleep disorders is often overlooked, but research has suggested that it occurs in a fairly large proportion of individuals with intellectual disabilities. Some researchers have reported that sleep stages are different in people with severe brain damage. Unregulated sleeping and waking cycles can contribute to behavioral challenges.

If you notice any of the following symptoms, you should consider the possibility of a sleep disorder:

- Severe snoring or irregular breathing
- Excessive daytime fatigue
- Late afternoon fatigue
- Changes in the individual’s functioning level
- Difficulty with mornings

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**Section 5: Specific Psychiatric Diagnoses: Psychoses and Other Disorders**

- Individual takes psychotropic meds, particularly several in the same class

**Page 27 Decision Tree for Sleep Disorders**

You can help determine whether a person has insomnia or if there may be some underlying condition causing their sleep difficulties. Many times, establishing good sleep habits and routines is all a person needs to improve sleeping. There are other types of sleep disorder, however, that require more specialized assessment.

**Click here** to see a decision tree that helps you differentiate chronic insomnia from other sleep disorders. This series of steps is also a model for how you can organize questions to investigate all possible reasons behind a person’s behavior.

**Page 28 Dementia**

It is not known what percentage of people with intellectual disabilities experience dementia. While some types of dementia are reversible, others are not. In either case, it seems that early treatment can slow the process of even irreversible dementia, particularly in the case of Alzheimer’s disease. Therefore, it’s important to be aware of this potential.

**Page 29**

Ask the following questions to determine whether dementia may be present:

- Has there been a change in the person’s skill level, including self-care?
- Is the person participating less in activities they used to enjoy?
- Could the person have some depression creating symptoms of dementia?
- Is there a family history of dementia?
- Have you noticed any disturbances in how the person walks or moves?

**Page 30**

To determine whether a person is experiencing dementia a full medical history and health examination is needed. All the available information should be considered, including mental status evaluations, specialized tests (like an MRI), and the results of routine tests. This is needed to rule out any underlying conditions that might be causing the problems.
Section 5: Specific Psychiatric Diagnoses: Psychoses and Other Disorders

1. Psychosis is defined as:
   - Objects or sensations not caused by external stimuli
   - Strongly held but incorrect belief
   - A state where a person loses touch with reality
   - Total lack of movement

2. Personality disorders represent long-term patterns of behavior and inner experience that:
   - Cause harm to the individual
   - Require strong medical to control
   - Are very different from what is considered normal in the individual’s culture
   - Are marked by paranoia and aggression

All of the following can mimic symptoms of psychosis except:
   - Untreated medical conditions
   - Complex life histories
   - Certain sensory deficits
   - Some usual behaviors for people with moderate to severe ID

Section 6: Conclusions

Whether or not you have the training to provide a person with an official diagnosis, people in all different roles provide valuable information to an assessment. Support providers can provide feedback about the effectiveness of a person’s medication, the severity and duration of their symptoms, and even notes like, “Jim gets upset when we brush his teeth (possible dental problem).”

People with a day-to-day knowledge of individuals can offer a voice when they are having trouble communicating all that is going on.
Section 6: Conclusions

Thinking back to Amer and Jim – Jim is probably not going to be able to communicate about how he was feeling or acting the week or month before, but Amer can. Amer is an important link in the chain. Medical doctors and clinicians can only treat what immediately in front of them. They need more information than what they can see on any given day. Getting that additional information is invaluable.

Whether or not you are a mental health professional trained to give these diagnoses, your input is still very important!

a. To help identify the class of the disorder
   (mood, anxiety, psychotic disorder)

b. To help identify how long the person experienced the symptoms

c. To help identify if treatments are working

Page 4 Factors to Consider

As we have seen, there are many different kinds factors that needed to be taken into account in a whole-person assessment, including:

- Developmental, medical, psychiatric histories
- How a person communicates and what supports they prefer to use
- Behavioral challenges
- Self-help skills (grooming, bathing, dressing, toileting, eating)

Page 5 Everyday Life

If you work closely with someone every day, you might be aware of things like:
Section 6: Conclusions

- Changes in mood, social activity, or ways of communicating
- Changes in posture, gait, or physical behavior
- Recent falls or head injuries
- Changes in health or cognitive functioning (related to disability or not)
- Side effects of medications
- Refusal or cheeking of medications
- Personal and family history and dominant memories
- Communication preferences and level of expressive and receptive language skills
- Behavioral challenges and recent incidents
- Triggers for behavioral problems
- Changes in energy level, sleep, alertness
- Tendencies toward self-harm
- Compulsive or ritualistic behaviors
- Changes in eating and toileting routine

All of these observations would be relevant to an assessment that is aimed at a total picture of a person’s mental health.

Page 4 Ruling Out/Ruling In

Anna is a 35-year old Caucasian woman who lives in an adult’s residential facility with five other residents. She has a history of self-injurious behavior which involves pricking her skin. This behavior is usually localized on her arms. Sometimes in the past this behavior has resulted in open wounds, but incidences of skin picking have decreased significantly over the past several years.
Section 6: Conclusions

Page 5

Within a few weeks, however, Anna’s behavior has been increasing not only in frequency, but also in intensity. It has increased to such an extent that behavior consultation services have been requested because her skin is becoming very raw. Anna has started to pick at her knees, hands, and arms, which was a change in her usual presentation. All this is now accompanied by restlessness, pacing, difficulty sitting still, decreased attention span, and insomnia. Earlier episodes were not accompanied by this type of restless behavior. Anna is nonverbal and diagnosed with Severe Intellectual Disability, and Obsessive-Compulsive Disorder. She is not on any medications.

Page 6

Because Anna has a history of skin picking and has been diagnosed with Obsessive-Compulsive Disorder, it might seem logical that her current behavior could be attributed to these known conditions. In this case, however, staff took the time to explore all the options. They found that Anna had recently changed bedrooms and was sleeping on a donated mattress. It turned out that she had scabies, which she apparently caught from the donated mattress. Her scabies was treated and her skin healed.

Page 7

Avoid Making Assumptions

Try to avoid jumping to conclusions. When you are confronted with “problem behavior,” go back to basics: Make a list of all the possible causes and work as a team to investigate them.

Page 8

An interdisciplinary approach, drawing from a diverse support team is needed to put together the right supports needed by individuals with a dual diagnosis. Not every member of a team will consider all factors equally. If everyone takes responsibility to review each component, it is more likely that a comprehensive plan will be developed.

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Summary


Section 6: Conclusions

Now that you have reviewed the material in this course, you should be able to:

1. Explain what dual diagnosis is and why it is challenging for people to receive the right services.

2. Practice appropriate and effective communication strategies with a person who has limitations in receptive and effective language skills.

3. Name 3 mental illnesses, their characteristic symptoms, and some of the symptoms they might create in a person with intellectual disabilities.

4. Identify some of the different types of information you can contribute to an individual’s assessment.

Page 10 Put Into Practice

Using What you Have Learned

1. Think of a person you support who you think would benefit from more attention to mental wellness. What is it about this person that made you pick them? Why do you think this aspect of their life may have been overlooked?

2. Think of a person you support who been diagnosed with another serious medical or psychological condition. Does their intellectual disability make it easier, harder, or does it have no effect on their ability to get treatment for their other condition?

3. A person you are supporting experiences a sudden change in mood over several weeks. What do you do to investigate the reasons for this change? What are the different resources and roles that you have to draw from?

Page 11 Work Portfolio
Section 6: Conclusions

If you are making a work portfolio to showcase your work experience, click here to download potential projects to consider that will allow you to document the skills you have gained in this course. The projects include:

1. Relationship History Map
2. Expression Feelings (a group or individual discussion)
3. Different Modes of Expression (tell a story without using words!)

Page 12 Congratulations!

You have finished reviewing the course content!